TLC Care Homes Limited

Little Millfields

Inspection report

21 Mill Lane
Weeley Heath
Essex
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13 April 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 8 April 2016 and 13 April 2016 and was unannounced.

Little Millfields provides accommodation and personal care for up to five people who have learning disabilities or who are on the autistic spectrum. The service does not provide nursing care. At the time of our inspection there were five people using the service.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported to manage the service on a day-to-day basis by the home manager.

People were safe because the management team and staff understood their responsibilities in identifying abuse. People received safe care that met their assessed needs.

People were safe because staff supported them to understand how to keep safe and staff knew how to manage risk effectively.

There were sufficient staff who had been recruited safely and who had the correct skills and knowledge to safely meet people's needs.

The provider had systems in place to manage medicines and people were supported to take their prescribed medicines safely.

People's health and social needs were managed effectively with input from relevant health care professionals and people had sufficient food and drink that met their individual needs.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the provider was following the MCA code of practice.

The management team supported staff to provide care that was centred on the person and staff understood their responsibility to treat people as individuals.

People were treated with kindness and respect by staff who knew them well. Staff respected people's choices and took their preferences into account when providing support. People were encouraged to enjoy pastimes and interests of their choice and were supported to maintain relationships with friends and family so that they were not socially isolated.

Staff had good relationships with people who used the service and were attentive to their needs. People's privacy and dignity was respected.

There was an open culture and the management team encouraged and supported staff to provide care that was centred on the individual.

The provider had systems in place to check the quality of the service and take the views and concerns of people and their relatives into account to make improvements to the service.

The provider had systems in place so that people could raise concerns and there were opportunities available for people or their representatives to give their feedback about the service.

The registered manager and the home manager were visible and actively involved in supporting people and staff. Staff were positive about their roles and their views were valued by the management team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Staff understood how to protect people from abuse or poor practice. There were processes in place to listen to and address people's concerns.

There were sufficient staff who had been recruited appropriately and who had the skills to manage risks and care for people safely.

The premises were well managed to meet people's needs safely.

Systems and procedures for supporting people with their medicines were followed, so people received their medicines safely and as prescribed.

Is the service effective?

Good

The service was effective.

Staff received the support and training they needed to provide them with the information to provide care effectively.

Where a person lacked the capacity to make decisions, there were correct processes in place to make a decision in a person's best interests. The Deprivation of Liberty Safeguards (DoLS) were understood and appropriately implemented.

People's health, social and nutritional needs were met by staff who understood their individual needs and preferences.

Is the service caring?

Good

The service was caring.

Staff treated people well and were kind and caring in the way they provided care and support.

Staff treated people with respect, were attentive to their needs and provided care in a dignified manner.

Staff understood how to relieve distress in a caring manner.

People were encouraged to be as independent as they were able to be.

Is the service responsive?

Good

The service was responsive.

People's choices were respected and their preferences were taken into account when staff provided care and support in line with their individual care plans.

Staff understood people's interests and encouraged them to take part in pastimes and activities that they enjoyed. People were supported to maintain family and social relationships with people who were important to them.

There were processes in place to deal with concerns or complaints and to use the information to improve the service.

Is the service well-led?

Good

The service was well led.

The service was run by a capable management team who demonstrated a commitment to provide a service that put people at the centre of what they do.

Staff were valued and they received the support they needed to provide people with good care and support.

There were systems in place to monitor the quality of the service, to obtain people's views and to use their feedback to make improvements.

Little Millfields

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 April 2016 and 13 April 2016. The inspection was unannounced. The inspection team consisted of one inspector.

We reviewed all the information we had available about the service including notifications sent to us by the manager. This is information about important events which the provider is required to send us by law. We used this information to plan what areas we were going to focus on during our inspection.

The five people who lived at Little Millfields at the time of our inspection were unable to speak with us because of their complex needs. We were able to observe people's care and support and our observations were carried out discreetly so that any intrusion into their daily lives was minimised. We used informal observations to evaluate people's experiences and help us assess how their needs were being met and we saw how staff interacted with people.

We spoke with two relatives of people who used the service about their views of the care provided. We spoke with the registered manager, the home manager, senior care staff and three members of the care team. We also received feedback from a social care professional.

We reviewed three people's care records, including medicines records and risk assessments. We examined information relating to the management of the service such as health and safety records, three sets of recruitment and personnel records, staff rotas, quality monitoring audits and information about complaints.

Good

Is the service safe?

Our findings

A relative told us they were confident their family member was kept safe. They said, "If anything happened to me [my family member] would be safe there." and another relative said, "I think they keep [my family member] safe."

Staff had received training in safeguarding and understood their responsibilities to keep people safe and protect them from harm. Staff knew how to recognise abuse or poor practice and promptly reported any issues of concern. We saw that, when staff had raised some concerns about an incident of poor practice, the management team had acted promptly and raised a safeguarding alert with the local authority. The local authority investigated and the provider took action following the provider's disciplinary processes. Input was sought from an advocate to support the person as they did not have capacity to speak for themselves.

We saw that there were processes in place to identify risk and there were clear risk assessments in place. When a risk had been identified, for example risks associated with accessing the community, the risk assessment recorded what measures were already in place to reduce the risk and these were reviewed regularly to assess whether any further actions were required. There were detailed strategies in place for supporting people with identified behaviours and associated risks.

People who lived at the service did not have the capacity to manage their finances. Either relatives managed people's finances on their behalf or money was managed independently by Essex Guardians. Essex Guardians provides a service to handle financial affairs for people when they do not have the mental capacity to manage their own finances or if no suitable alternatives exist and the task can no longer be administered on their behalf by friends or relatives.

The management team and senior staff carried out a range of health and safety audits to monitor the safety of the premises. Water temperatures were checked to minimise the risk of accidental scalding and regular tests were carried out on emergency lighting, fire alarms and fire equipment. A senior member of the care team explained the procedure to be followed in the event of a fire and also gave positive feedback about the practical fire training that staff had received. We saw that a full annual health and safety review had recently been carried out.

Staff files were well organised and there was evidence of a strong recruitment process. The management team demonstrated the importance of recruiting staff with the right qualities to meet the demands of the role. We saw that each person had one-to-one staffing when at the service. Some people with complex behaviours that may have put themselves or others at risk when accessing the community were supported by an additional member of staff. In addition to the team of care staff, there was a home manager and the registered manager who also provided hands on care. During our inspection we saw that the staffing levels met people's needs and were sufficiently flexible to give staff breaks in difficult situations.

A senior member of staff explained that the service had a clear system for supporting people to take their medicines. The medicines were delivered from the pharmacy in monitored dose packs and there was a

photograph on each person's individual medicines administration record (MAR) sheet to minimise the risk of administering medicines to the wrong person. The member of staff was also able to give examples of how each person took their prescribed medicines. For example, one person would throw the medicine pot away unless the member of staff held it near the person's mouth to indicate that the medicines were for swallowing, they would then take the pot and their medicines. Senior staff carried out weekly and monthly audits of medicines and if there were any issues identified, an untoward incident form was completed. This information was used to put measures in place to prevent a reoccurrence. We saw from people's MAR sheets that they had been completed appropriately. Each person had a 'person centred medicines support plan' which identified how the person preferred to take their medicines and what support was required.

Senior staff who administered medicines had received medicines training and this was also being rolled out to all staff to reinforce their understanding of people's prescribed medicines.

As people were non-verbal, care records recorded how people gave consent to take their medicines. For example, one person's care plan stated, 'I will open my mouth and put my hand out. If I don't want to take them I may knock them out of your hand.' As people did not have the capacity to understand what their medicines had been prescribed for, an assessment had been carried out following Mental Capacity Act guidelines and best interest decisions were in place with input from health professionals. There were clear instructions for staff about what they had to do if someone refused their medicines.

People had been prescribed medicines to be given on an 'as required' basis, usually referred to as PRN medicines. For example, people could be prescribed a rescue medicine to be used when someone with epilepsy had an uncontrolled seizure. We saw that PRN protocols were in place that clearly set out the circumstances when staff were able to administer the medicine.

Good

Is the service effective?

Our findings

Relatives were complimentary about staff. One said, "The guys do a pretty good job." Another relative said, "The staff are very good, [my family member] responds well to them."

Staff knew people well and were skilled in providing support to meet individuals' complex needs, including how to support a person whose anxieties could present as aggressive behaviours. A social care professional provided positive feedback about how a member of staff managed a situation well during a care review. The professional was complimentary about how the member of staff handled the difficult situation calmly, carried on with the review and maintained professionalism throughout.

Newly recruited staff started their induction with a week of training at head office and all mandatory training was delivered. Following the induction period there were two weeks of 'shadow training' where each new starter was assigned a buddy for support. The induction continued with a booklet that followed skills covered by the care certificate. The care certificate is a set of standards that social care and health workers follow in their daily working life. It is the new 'minimum standards' that should be covered as part of induction training of new care workers. Newly recruited staff kept their evidence booklets until they were signed off by management.

We saw evidence of a wide range of training, including training to meet the specific needs of people who lived at the service. Staff had a good knowledge of autism awareness, epilepsy, the Mental Capacity Act and Deprivation of Liberty Safeguards. Due to people's complex communication needs staff had completed a course developed by speech and language therapists called Inclusive Communication in Essex (ICE) and had also been trained in Makaton, a language system using signs and symbols to communicate. We saw that staff communicated effectively with people and were able to explain that they understood individual communication needs. There was a training spreadsheet in place that recorded when staff had attended training and when updates were due. Three members of staff were working on their Quality Compliance Systems diplomas and three other staff had already completed this award.

A member of the care team told us, "The training is the best. We get yearly updates and fire training is every three years." They said that there was on-going training at one of the provider's other locations and explained they had completed a range of courses including autism awareness, sensory training and training specific to people's individual needs.

Staff received the training they needed to deal with challenging and aggressive situations. This included PRICE training (Protecting Rights in a Caring Environment). A member of staff described how they met with other professionals such as the 'Intensive Support' team so that professional expertise and best practice was followed to develop the person's plan of care. Staff were able to give us examples of the different strategies that were used in a variety of situations.

There was a structured process in place for supporting and supervising staff. The registered manager, the home manger, assistant manager and assistant team leaders all had responsibilities for carrying out

supervisions. Members of staff had formal one-to-one supervisions six times a year and additional observations were carried out. For example, we saw records of an observation for a member of staff carrying out the weekly medicines audit. We also examined 'records of conversations' to address issues such as confidentiality. People had annual appraisals of their performance and a personal development plan to identify any training that was required. Assistant team leaders who had responsibilities for supervising care staff had received supervision training to enable them to provide effective support.

New members of staff received additional support through more frequent, monthly supervisions and observations. Team meetings were also scheduled monthly to give staff a forum to discuss care and support. In addition staff had appraisal meetings approximately every three months to set targets for their performance.

Where there were any identified issues, such as staff performance, a record was kept of discussions and staff development was monitored through on-going supervision. Strategies used to improve performance included mentoring, setting targets or providing additional training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care records confirmed that MCA assessments were carried out to assess people's ability to make day-to-day decisions. The management team demonstrated a clear understanding of their responsibilities under the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were.

Each person's care records contained assessments of their capacity to make day-to-day decisions and staff were aware of the decisions that people were able make and those decisions that were made by others on their behalf and in their best interests. Exterior doors could only be accessed with the support of staff and doors in the kitchen cupboards were locked for safety reasons. As there were restrictions in place appropriate DoLS applications had been made to the local authority and had been approved. All the people living at the service had DoLS authorisations in place.

Relatives explained that their family members health needs were met with input from relevant health professionals. One relative said, "If [my family member] is ill they get a doctor." Another relative explained that they liked to be involved in their family member's healthcare and went along to appointments with them, but sometimes had to remind staff about dentist and chiropodist checks.

People's care records had clear information about people's health needs. Their individual health needs were monitored and input from relevant health professionals was sought. We saw that there were seizure management plans in place for people with epilepsy, which were based on the model care plan devised by the Joint Epilepsy Council. These plans were put in place with input from the community nurse specialist. Staff received specific training to understand how to support people with epilepsy and how to safely administer rescue medicine such as Buccal Oromucosal which is prescribed for use in situations where a person does not show signs of coming out of an epileptic seizure after a sustained period of time.

We saw records of input from a range of health professionals to support people with needs around continence, epilepsy and nutrition. People were also supported to visit dentists, doctors, opticians and chiropodists when necessary.

People had 'hospital grab files' that contained essential information about the person to accompany them when they had an appointment with a health professional or for use in the event of an emergency admission to hospital. People and their relatives could be confident that essential information was available, including a record of the person's medicines, any health issues or conditions, the support required and any behaviour that could be triggered in a stressful situation. There were also essential contact details including the person's next of kin.

Staff and people living at the service ate meals together so that mealtimes were a social experience. Where people preferred, they ate alone or at their own individual table. We saw that people were encouraged and supported to make their drinks and snacks.

The Speech and Language Therapy Team (SALT) team had input into assessing people who had difficulties with swallowing. They carried out assessments to identify the risks to individuals who had problems with swallowing and were at risk of choking. All staff had received training on how to provide appropriate support for people at risk and there were guidelines in place which had been compiled with input from SALT. Care plans were in place so that staff had the information they needed to support people safely with their nutrition.

A relative told us that they felt improvements could have been made in the support their family member received around avoiding certain foods and they said they had had a conversation about this with the home manager. The manager was able to tell us about special diets, including foods that should be avoided. The manager said that people had individual meals and were supported where possible to help prepare their own food. People had their own cupboards in the kitchen where their individual food was stored.

Relatives told us that there was a "good layout" to the premises where people could have their privacy and their own space. We saw that the environment had been adapted to meet the needs of individuals. One person had their own self-contained space where they could spend time alone. Another person had areas of their bedroom, such as the headboard of the bed, protected by padding to avoid injury when they became anxious or distressed.

Good

Is the service caring?

Our findings

A relative told us, "Staff know [my family member] really well." Another relative said, "Staff are kind and really good with [my family member]. The staff are very caring."

Staff knew people well and understood how to communicate with them. We observed staff using different ways to engage with people. During our inspection we heard care staff speaking with people in a kind and caring manner, where necessary sitting down beside them and making eye contact to engage their attention.

A relative confirmed that the service supported their family member to maintain or increase their independence. They told us, "Absolutely. [My family member] tries to be independent and over time we have noticed a change."

We saw how staff promoted people's independence while they were providing care and support. For example when someone wanted something to eat, staff supported them in the kitchen to have as much input into the preparation of the food as they could. Staff explained that input from some people may be to get something from their cupboard with prompting or others may be able to make their drink independently or with prompting and supervision. Encouragement was given in a calm and reassuring way.

Staff understood each individual and were able to explain some of the things that could cause upset. They gave us examples of situations that caused distress for different people. Staff demonstrated that they understood how to support individuals when they were anxious or distressed and they explained the strategies they used to reduce people's anxieties.

A relative told us, "They're pretty good at keeping [my family member] calm. They know the signs." They explained about a medical procedure that needed to be carried out which had caused difficulties in the past but staff knew what to do to relieve the person's anxieties and their family member said they had co-operated well during the procedure. A member of staff told us they were in the process of making 'sensory bags' which could help provide distraction at times of distress.

We saw kind and caring interactions between staff and people in the service and, during our inspection, staff were cheerful and friendly. When staff were providing support with personal care, they were discreet and made sure they treated people with dignity and respect when meeting their care needs. One person's room had screening film on the windows so that they had more privacy but still had ample light.

Good

Is the service responsive?

Our findings

A relative told us, "I am happy with the care." They said that they visited regularly, were involved in decision making and explained that their family member viewed Little Millfields as their home. When they came to visit the family home they would ask to go back by making the sign for driving.

A member of staff told us, "Everyone is different." They explained about people's individual needs and the specific care and support needed to meet those needs in the way the person wanted. Our observations confirmed that staff knew people well and treated them as individuals.

Staff were positive that they had the information they needed to understand people's individual needs and they were knowledgeable about specific conditions including autism and epilepsy. Staff told us that their training gave them the information they needed to carry out their role. A senior member of staff explained how important it was to share information every day to make sure all staff were aware of important issues. There was a 15 minute handover at the end of every shift to discuss essential information so that people's care and support was consistent and met their specific needs on that day.

People's care plans were well organised and it was easy to locate information. The first section of each care plan contained a 'This is me' booklet which contained clear background information that included the person's history, how they communicated and their capacity for decision making. There was also a useful section that gave comprehensive information about the person's routines in the morning and the evening and what they liked to do during the day. There were specific details about what made the person happy, things they did not like as well as their individual health and personal care needs and preferences.

In addition to a person's main care plan, there were 'new starter' files in place. These contained essential information to be read by new members of staff so that they had an overview of issues that were important, such as a précis of how the person communicated, things that made the person happy or anxious, their dislikes and a brief overview of their health. The new starter file contained an overview of autism and of supporting people with behaviours that may be aggressive. This information was also useful if a member of agency staff was covering a shift in an emergency, so they could read the information before their shift commenced. Staff told us that because of the complex needs of the people supported at the service, agency staff worked closely with an established member of staff.

People at the service had complex needs and used a range of ways to communicate according to their individual abilities. All staff had received training in dysphasia to enable them to understand the impairment of people's ability to communicate. All the people who lived at Little Millfields used non-verbal means of communication. There had been input from Speech and Language Therapy Services (SALT) to support staff to find ways of improving communication such as using objects of reference. For example, one person used a communication board and another person used an electronic tablet with speech aids that had been recommended by SALT. Staff understood the importance of effective communication so that people could be involved in making decisions about how they spent their time.

Staff knew people well and were able to describe their likes, dislikes, preferences and situations that could make them anxious. The home manager explained that it was a long process to get a good understanding of what people responded to and what they liked to do. They had created activity planners both for in-house pastimes and community activities. To develop individual plans they used both experiences of how people responded to a particular activity and individual communication tools to find out what people wanted to do. Trips out, pastimes and interests were all carried out individually and were flexible depending on whether the person wanted to do something on that particular day.

People had individual holidays so that they could receive the specific support they needed to enjoy time away from the service. For example one person went to a caravan park and another preferred to stay at home because travelling and sleeping in unfamiliar environments increased anxiety levels. So that the person did not miss out on a holiday, a range of day trips were arranged such as going to a sea life centre but then returning to the security of familiar surroundings at the end of the day. A relative told us that their family member had gone on a holiday to a forest village and enjoyed it very much. They said, "It was good for [my family member]. They were able to go swimming and go for walks in the forest. They also described a boat trip which their family member loved because they enjoyed the wind blowing on their face.

A relative explained the level of support their family member needed when at the service and the additional support they needed when out in the community. They told us, "There can be staff shortages." They said that it did not mean their family member was not receiving the correct individual support but they may not have been able to go out as much at times when there were not enough drivers. On an odd occasion there had not been a driver available to bring their family member home for a visit but it had not happened often. They would have liked their family member to go out more frequently when they were well enough, for example to go swimming or to the zoo which they enjoyed.

The management team and staff supported people to keep in touch with their families and people who were important to them in a variety of ways. A relative told us, "They phone regularly and tell me what [my family member's] been doing. One person was supported to visit the family home on a regular basis and relatives visited people. Some families used internet technology to have face-to-face communication with their relative. A relative said, "They SKYPE me so that [my family member] can see me." Where relatives were unable to visit the manager used other methods of communication such as regular emails and sending pictures.

Relatives told us that they were able to talk to staff or the manager and were certain they could raise concerns and would be listened to. One relative said that they had a good relationship with staff and would speak to them if there were any issues. Another said, "They listen if I have a concern." They also told us they were very confident that they knew how to raise issues and would not hesitate to do so if the need arose.

The home manager explained how they worked hard to develop good relationships with families so that they will be confident they could raise any concerns and they would be addressed. Relatives who visited regularly told us they brought up any concerns as and when they arose. The manager explained that when people go to visit relatives they have a 'home book' to take with them so that family members can write any issues or information to go back to the service.

Good

Is the service well-led?

Our findings

Relatives were complimentary about how the service was managed. One told us, "The home manager is very good."

We saw that the home manager took a hands-on role and worked alongside staff, observing care and modelling good practice. Staff told us they felt well supported by the management team. One member of staff explained that the complex needs and challenges of dealing with aggressive behaviours could be stressful. They said that there was a system of 'debriefing' in place so that if they had experienced stressful situations they could discuss it, receive support and reflect on whether there was anything else they could have done or avoided doing in the situation. They also felt that they were supported to understand not just how to manage stressful situations but they received the training to understand why they occurred.

A member of staff told us, "We have a really good team" and said they supported one another. Staff told us that team meetings were held so that staff could discuss issues relating to people's care.

The provider made resources available when improvements were required. The home manager explained that when equipment went wrong there were no problems with getting it replaced.

The provider had systems in place for checking and monitoring the quality of the service. Part of the processes to improve the quality of the service was to seek the views of people using the service and others acting on their behalf. The provider sent quality assurance surveys to relatives, staff and professionals; feedback from the surveys was collated and actions to take were developed from the information received.

A new system had been introduced to monitor the quality of the service and drive improvement. This commenced with a report to record the improvements that had already been implemented and identify what further improvements were needed. Registered managers carried out monthly quality checks and audits on processes such as medicines. The Director of Operations monitored the leadership of the service to assess whether the service was well led.

There were systems in place for managing records. People's care records were well maintained and contained relevant information. All records examined including people's care records, personnel records and health and safety documents were up to date. All documents relating to people's care, to staff and to the running of the service were kept securely when not in use. People could be confident that information held by the service about them was confidential.

Notifications about incidents were submitted to the Care Quality Commission (CQC) as required by regulations. Information in notifications was clear and well detailed, informing us how incidents were managed and, where relevant, what measures were in place to reduce the risks of further similar occurrences. The registered manager promptly raised alerts with the local authority in the event that a safeguarding concern was identified and liaised with the safeguarding team to take appropriate measures to address any areas of potential abuse or poor practice. The management team were able to demonstrate

and give examples of how they reviewed incidents and used the information used to make improvements to the service.